3. For Rate Year 2001, there will be no Transition Payment and all facilities will receive the Other Operating Standard Payment.

(3) Capital Payment Rates - Beds licensed prior to February 1, 1998.

(a) The Capital Payment is determined based on the facility's Allowable Fixed Costs and Equity per diem amounts effective January 31, 1998 calculated pursuant to 114.2 CMR 5.00. This includes amounts approved under 114.2 CMR 5.12.

1. If the sum of a facility's Allowable Fixed Costs and Equity or Use and Occupancy payments is greater than $17.29 per day, the facility's 1999 Capital Payment will be the greater of 90% of the sum of its 1997 Allowable Fixed Costs and Equity or Use and Occupancy payments or $17.29 per day.

2. If the sum of a facility's Allowable Fixed Costs and Equity or Use and Occupancy payments is equal to or lower than $17.29 per day, the facility's 1999 Capital Payment will equal the sum of its 1997 Allowable Fixed Costs and Equity or Use and Occupancy payments.

(b) Reopened Beds out of Service. Facilities with licensed beds that were out of service prior to 1997 and which re-open in 1999 will receive a Capital Payment of the lower of $17.29 per day or the facility's most recent billing rates for Fixed Costs and Equity or Use and Occupancy.

(4) Capital Payment – New Construction. Except for new construction pursuant to a Determination of Need approved after March 7, 1996, and construction in urban underbedded areas which becomes operational after February 1, 1998, which are governed by 114.2 CMR 6.03(2), the Division will calculate Allowable Fixed Costs and Allowable Equity or Use and Occupancy.

(a) Allowable Basis of Fixed Assets. The Allowable Basis of Fixed Assets is used to calculate allowable depreciation, interest, equity, and use and occupancy.

1. Fixed Assets include Land, Building, Improvements, Equipment and Software.

2. Allowable Basis. The Allowable Basis is the lower of the Provider's actual construction cost or the Maximum Capital Expenditure approved for each category of assets by the Massachusetts Public Health Council. The Division will classify depreciable land improvements such as parking lot construction, on-site septic systems, on-site water and sewer lines, walls and reasonable and necessary landscaping costs as Building cost.

3. Allowable Additions. The Division will recognize Fixed Asset Additions made by the Provider if the Additions are related to the care of publicly-assisted Residents. If Additions relate to a capital project for which the Department has established a Maximum Capital Expenditure will be limited to the amount approved by the Department. The Division will not recognize Fixed Asset Additions made or Equipment Rental expense incurred within 12 months after a DON project becomes operational.

4. Change of Ownership. If there is a Change of Ownership, the Allowable Basis will be determined as follows:

a. Land. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis.

b. Building. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates for the years 1968 through June, 30, 1976 and 1993 forward. In addition, the seller's allowable Building Improvements will become part of the Allowable Building Basis of the new owner.

c. Improvements. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in

the Medicaid rates. The seller's allowable Building Improvements will become part of the new owner's Allowable Basis of Building.

d. Equipment. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates.

e. Upon transfer, the seller's allowable Building Improvements will become part of the new owner's Allowable Basis of Building.

f. If the Division cannot determine the amount of actual depreciation allowed in a prior year from its records, the Division will determine the amount using the best available information including, among other things, documentation submitted by the Provider.

5. Special Provisions.

a. Non-Payment of Acquisition Cost. The Division will reduce Allowable Basis if the Provider does not pay all or part of the acquisition cost of a reimbursable fixed asset or if there is a forgiveness, discharge, or other non-payment of all or part of a loan used to acquire or construct a reimbursable fixed asset. The Division will reduce the basis to the extent that the basis was derived from the acquisition or construction cost of the fixed asset.

b. Repossession by Transferor. The Division will recalculate Allowable Basis if a transferor repossesses a facility to satisfy the transferee's purchase obligations; becomes an owner or receives an interest in the transferee's facility or company, or acquires control of a facility. The Allowable Basis will not exceed the transferor's original allowable basis under Division regulations applicable at the date of Change of Ownership , increased by any allowable capital Improvements made by the transferee since acquisition, and reduced by depreciation since acquisition.

(b) Allowable Fixed Costs. The Division will calculate Allowable Fixed Costs including depreciation, interest, real estate taxes, Building insurance and Equipment rental as defined below:

1. Rent and Leasehold Expense. The Division will allow reasonable rental and leasehold expenses for Land, Building and Equipment at the lower of: average rental or ownership costs of comparable Providers, or the reasonable and necessary costs of the Provider and lessor including interest, depreciation, real property taxes and property insurance. The Division will not allow rent and leasehold expense unless a Realty Company Cost Report is filed.

2. Depreciation. The Division will allow depreciation on Buildings, Improvements and Equipment based on the Allowable Basis of Fixed Assets.

a. Methodology. Allowable Depreciation is calculated using the straight line method.

b. Useful Lives. Except as provided below, Allowable Depreciation is calculated using the following useful lives:

ASSET	TYPE	USEFUL LIFE	DEPRECIATION RATE
Building	Class I or II as classified by the Department of Public Safety	40	2.5%
	Class III or IV as classified by the Department of Public Safety	33	3.0%

	A Building owned and operated by a political subdivision of the Commonwealth or an authority or which was financed by municipal bonds.	20	5%
Building Improvements	Building or leasehold Improvements made subsequent to the beginning of the Rate Year must be pro-rated over the life of the lease or the balance of the estimated life of the Building as determined above, but in no case to exceed the yearly rate of 5%.	Various	up to 5%
Equipment , Furniture and Fixtures		10	10%
Motor Vehicle Equipment		4	25%
Software		3	33.3%

3. Long Term Interest Expense.

a. Reimbursable Debt. Subject to the limitations on refinancing set forth below, the Division will recognize a long term debt as reimbursable if it is obtained to finance assets used in the care of publicly-assisted patients and if it is supported by allowable depreciable fixed assets.

i. The Division will recognize debt related to the financing of a new fixed asset only if the acquisition and financing occur concurrently. A grace period of not more than 90 days between the date of acquisition and financing is permitted if the Provider can present sufficient documentation to support its claim that all reasonable attempts were made to finance the asset at the time of the acquisition.

ii. The Division will not allow interest expense on loans to the facility from an owner, officer, or Related Party.

iii. The Division will not offset interest income against interest expense.

iv. Mortgage Acquisition Costs. Mortgage Acquisition Costs must be amortized over the life of the mortgage. Amortized mortgage acquisition costs are treated as Long Term Interest Expense. Mortgage Acquisition Costs are subject to the provisions of maximum interest rates and permanent factors, if applicable.

b. Refinancing. The Division will recognize the refinancing of an existing allowable debt as an allowable debt under the following circumstances:

i. Crossover. When the accumulated principal payments on the existing, allowable debt exceeds the accumulated depreciation allowed by the Division on the allowable fixed assets which have been financed by that debt; or

ii. Demand Note. When an existing, allowable debt becomes payable upon demand; or

iii. Lowered Expense. When the Long-Term Interest Expense over the life of the refinanced debt is lower than it would have been under the remainder of the existing, allowable debt. The Provider must submit comparative schedules showing total Long-Term Interest Expense under both the existing, allowable debt and the re-financed debt.

iv. Financing of Allowable Additions. When a Provider refinances for amounts greater than the existing, allowable debt and the additional indebtedness is used for a significant addition of allowable depreciable fixed assets. If the refinancing is for amounts greater than the existing, allowable debt on the date of the refinancing and the additional indebtedness is used for purposes other than a significant addition of allowable depreciable fixed assets, the Division will not recognize interest expense on the additional indebtedness. When a Provider refinances for amounts greater than the existing, allowable debt on the date of refinancing and the additional indebtedness is used for the addition of allowable depreciable fixed assets which are not significant, only the portion of the refinancing related to the financing of the newly acquired fixed assets will be allowable.

c. Non-recognized Debt. If the refinanced debt is not allowable, the Division will continue to include in the rates the amount of Long Term Interest Expense which would have been incurred on the prior allowable debt. The Division will include the lower of the interest which would have been incurred or the actual Long-Term Interest Expense actually incurred by the Provider.

d. Permanent Factor for Interest. The Division will recognize interest on an allowable debt to the extent that such debt is supported by depreciable fixed assets. Land and Mortgage Acquisition Costs are not depreciable fixed assets. The Division will calculate the percentage of allowable debt to total debt by dividing the allowable basis of depreciable fixed assets by the total amount of the reimbursable debt. Upon refinancing, the Division will recalculate the Permanent Factor by dividing the prior allowable mortgage balance by the total amount of the new debt.

e. Allowable Interest Rate. The allowable interest rate is the lower of the percentage of total Long-Term Interest Expense divided by the average outstanding principal during the reporting period, or the annual percentage rate on special issues of the public debt obligations issued by the Federal Hospital Insurance Trust Fund for the third month prior to the month in which the financing was incurred plus 3%. The allowable interest rate applies throughout the life of any debt and will continue to apply if the Provider refinances an allowable debt which is not recognized.

(c) Calculation of Allowable Fixed Costs per diem:

1. The Division will calculate total Allowable Fixed Costs by adding allowable depreciation, allowable Long Term Interest Expense, Real Estate Taxes, Personal Property Taxes on the Nursing Facility Equipment; the Non-Income portion of the Massachusetts Corporate Excise tax; Building Insurance; and Rental of Equipment located at the facility.

2. The Division will calculate Allowable Fixed Costs per diem by dividing Allowable Fixed Costs by the Constructed Bed Capacity times the days in the Rate Year times the greater of 96% or the Actual Utilization Rate in the Rate Year. For the first twelve months of operation, Allowable Fixed Costs will be divided by the greater of actual Patient Days or 96% of Maximum Available Bed Days.

(d) Equity and Use and Occupancy Allowance. The Division will include a return on Average Equity Capital for Proprietary Providers. The Division will include a Use and Occupancy Allowance for certain Non-Profit Providers.

1. Average Equity Capital. Average Equity Capital is the average of the difference between the Provider's Allowable Basis of Fixed Assets as determined under 114.2 CMR 6.04(4)(a), and the Provider's allowable long-term liabilities at the beginning and end of the year. For equity, allowable long-term liabilities are total allowable debt supported by total allowable assets, including land.

a. The Division will reduce Average Equity Capital by depreciation allowed on the Building, Improvements, Equipment and software.

b. The Division will not include Mortgage Acquisition Costs, such as capitalized legal fees and prepaid interest on long-term obligations, or equity in Buildings and/or Equipment not located at the Nursing Facility, in Average Equity Capital.

c. The Division will not reduce Average Equity Capital by long-term loans for which interest has been excluded.

d. If a facility replaces beds, reimbursable equity will be recalculated using the newly established allowable fixed assets and allowable debt, exclusive of equity supplement, if any, which was previously granted pursuant to 114.2 CMR 5.00 for the structure to be replaced by the new construction.

e. Calculation of Average Equity Capital Allowance. The average equity capital allowance is calculated by multiplying Average Equity Capital by the Federal Hospital Trust Fund rate for September, 1998, or 5.375%.

f. The Division will calculate allowable Average Equity Capital per diem by dividing the Average Equity Capital Allowance by the current Licensed Bed Capacity, including Resident Care Units, times the days in the Rate Year, times the greater of 96% or the Actual Utilization Rate.

2. Use and Occupancy Allowance for Non-Profit Providers.

a. The Division will include a Use and Occupancy Allowance in the rates of Non-Profit Providers that have maintained a public occupancy rate, including Medicaid, Massachusetts Commission of the Blind, and Medicare Patient Days, of at least 70%.

b. The Division will calculate the Use and Occupancy Allowance by using the methodology set forth in 114.2 CMR 6.04(4)(e)1e and dividing the result by three.

c. The Division will calculate an allowable Use and Occupancy per diem by dividing the Use and Occupancy Allowance by the current Licensed Bed Capacity for the Rate Year, including Resident Care Units, times the days in the Rate Year, times the greater of 96% or the Actual Utilization Rate.

(e) Payment for Capital Costs.

1. The Division will calculate the sum of the facility's

a. Allowable Fixed Costs pursuant to 114.2 CMR 6.04(4)(c), and

b. Equity or Use and Occupancy Allowance pursuant to 114.2 CMR 6.04(4)(d).

2. For the following facilities, the Capital Payment will determined as follows: If the sum is greater than $17.29, the Capital Payment will be the greater of 90% of the sum or $17.29. If the sum is lower than $17.29, Capital Payment will equal the calculated sum. This Capital Payment applies to:

a. New Facilities and newly-licensed beds which open pursuant to a Determination of Need approved on or before March 7, 1996;

b. Replacement Facilities which open on or after February 1, 1998 pursuant to a Determination of Need approved on or before March 7, 1996;

c. Renovations made pursuant to a Determination of Need approved on or before March 7, 1996;

d.Twelve bed additions associated with a Determination of Need approved on or before March 7, 1996;

e. Facilities which requested and received an approved Determination of Need pursuant to the delegated review process in 1996 under Department of Public Health regulation 105 CMR 100.505(a)(4); and

f. Facilities that implement a transferred Determination of Need approved before March 7, 1996 and that filed a Notice of Intent to Acquire before March 7, 1996.

3. For the following facilities, the Capital Payment will equal the lower of the calculated sum or $17.29:

a. facilities which renovate pursuant to a Determination of Need approved after March 7, 1996; and

b. facilities that implement a transferred Determination of Need approved before March 7, 1996 but did not file a Notice of Intent to Acquire the facility before March 7, 1996. This provision will not apply if the transfer occurred on or after February 1, 1998 and before May 30, 1998. If the transfer occurred during this period, the Capital Payment will be determined under 114.2 CMR 6.04(4)(e)2.

4. If a facility's licensed beds fall into different Capital Payment methodologies, the Division will calculate the Capital Payment for each type of licensed beds. The Division will weight the capital payment rate based on the number of beds associated with each rate.

(5) Preliminary Payment Rates. The preliminary payment rates are the sum of the Nursing and Other Operating Payment Rates and the Capital Payment Rate. For hospital-based nursing facilities, the preliminary payment rates are the sum of the Standard Payments for Nursing and Other Operating Costs and the Capital Payment of $17.29 per day.

(6) Total Payment Adjustment. There is an additional adjustment to reflect the percentage change from the facility's 1999 weighted Preliminary Payment Rates and its weighted current payment rates.

(a) Current Payment Rates. A facility's current payment rates are its most recently certified rates effective December 1, 1998 calculated pursuant to 114.2 CMR 6.00. The Division will amend a facility's 1999 rates to reflect 1998 amended rates pursuant to 114.2 CMR 6.05(1).

(b) Calculation of Weighted Rates. The Division will calculate weighted 1998 rates as follows:

1. Using third quarter 1998 case mix proportions, calculate the "weighted current payment" as the sum of the products of each category's current payment by its corresponding case mix proportions.

2. Using third quarter 1998 case mix billing data, calculate the "weighted preliminary payment" as the sum of the products of each category's preliminary 1998 payment rate by its corresponding case mix proportions.

3. Calculate the percentage difference from the "weighted current payment" to the "weighted preliminary payment."

(c) Total Payment Adjustment.

1. If the percentage increase between a facility's 1999 weighted preliminary payment as calculated above and its 1998 weighted current payments is greater than 6%, the facility's rate adjustment from its current billing rates will be limited to 6%.

2. If a facility's 1999 weighted prelimlinary payment as calculated above is lower than the facility's 1998 weighted current payment, the facility's 1999 rates will equal its 1998 rates.

(d) The Total Payment Adjustment will not be recalculated as a result of Rate Year Adjustments made to Capital Payments Rates under 114.2 CMR 6.05(2).

(7) 1999 Add-on. The Division will add a one time adjustment of $0.76 to each rate calculated pursuant to 114.2 CMR 6.04(6).

6.05 Rate Year Adjustments

(1) Retroactive Adjustments. The Division will retroactively adjust rates in the following situations:

(a) Facilities which did not file a 1996 Cost Report. If a facility operational in 1996 did not file the 1996 cost report, the payment rates will be the lower of its current billing rates or the standard payment rates. If the facility does not file a 1996 cost report by May 1, 1998, the facility's rates will be lowered by 5%. If the facility does not file a 1996 cost report by July 1, 1998, the Division may terminate the facility's rates. If the facility files a 1996 cost report, the Division will calculate amended 1999 rates using the facility's 1996 cost report. The amended rate will be effective on the first day of the month following the receipt of an acceptable cost report. If the facility demonstrates that it cannot complete a 1996 cost report, it will continue to be paid at its current billing rates or it may request that the Division use a different base year cost report to determine its rates.

(b) Facilities that opened in 1997. A facility that opened in 1997 will receive its 1997 billing rates until a 1997 cost report is received. The Division will calculate the facility's 1998 rates using 1997 base year costs subject to cost ceilings updated to 1997. The cost adjustment factor to update Nursing and Other Operating Costs will reflect the change from 1997 to 1998. For facilities with lookback receiving divisor relief pursuant to 114.2 CMR 5.11, the Division will extend the divisor relief in the 1998 rate for the twelve months allowed but not beyond that point. When the divisor relief expires, the Division will recalculate the facility's 1998 capital payment based on constructed capacity.

(c) Facilities that open in 1998 or 1999. Rates for facilities that open in 1998 or 1999 will be set using $17.29 for Capital Costs during the Rate Year. The Division will review the costs reported in the Rate Year Cost Report to determine the Capital Payment under 114.2 CMR 6.04(4)e2.

(d) Amended 1997 and 1998 Rates. The Division will amend 1999 rates to reflect 1997 and 1998 amended rates for the following: offbase and lookback rates pursuant to 114.2 CMR 5.11, administrative adjustments pursuant to 114.2 CMR 5.12; amended rates pursuant to an administrative appeal; amended DON approvals for Maximum Capital Expenditures if the original Determination of Need was approved prior to March 7, 1996, or any further adjustments to reflect the results of any desk or field audits conducted by the Division or the Division of Medical Assistance.

(e) Mechanical Errors. The Division may adjust rates if it learns that there is a material error in the rate calculations.

(f) Errors in the Cost Reports. The Division may adjust rates if it learns that the Provider has made a material error in the cost report.

(2) Notification Process. All facilities must notify the Division and a file a submission when they open, add new beds, renovate or re-open beds.

(a) General Notification Requirements. All facilities must submit the following information: the Provider's name, address and VPN; a detailed explanation of the basis for the requested rate or rate adjustment;

(b) Submission for Rate Year Adjustments. A facility requesting a Rate Year Adjustment under 114.2 CMR 6.05(2) must also include the following information:

1. a copy of the construction contract;
2. copies of invoices and cancelled checks for construction costs;
3. a copy of the mortgage documents;

4. a copy of the Department's licensure notification associated with the new beds; and,
5. any other information the Division determines necessary to calculate a new rate or rate adjustment.

(c) Effective Date. A facility requesting a new rate or Rate Year Adjustment must file its submission with the Division during the rate year. The effective date of the new or adjusted rate will be the later of the date of the filing or the date on which the event occurred.

6.06 Reporting Requirements

(1)Required Cost Reports

(a) Nursing Facility Cost Report. Each Provider must complete and file a Nursing Facility Cost Report each calendar year. The Nursing Facility Cost Report must contain the complete financial condition of the Provider, including all applicable management company, central office, and real estate expenses.

(b) Realty Company Cost Report.. A Provider that does not own the real property of the nursing facility and pays rent to an affiliated or non-affiliated realty trust or other business entity must file or cause to be filed a Realty Company Cost Report.

(c) Management Company Cost Report. A Provider must file a separate Management Company Cost Report for each entity for which it reports management or central office expenses related to the care of Massachusetts publicly-aided residents. If the Provider identifies such costs, the Provider must certify that costs are reasonable and necessary for the care of Publicly-Aided Residents in Massachusetts.

(2) General Cost Reporting Requirements

(a) Accrual Method. Providers must complete all required reports using the accrual method of accounting.

(b) Documentation of Reported Costs. Providers must maintain accurate, detailed and original financial records to substantiate reported costs for a period of at least five years following the submission of required reports or until the final resolution of any appeal of a rate for the period covered by the report, whichever is later. Providers must maintain complete documentation of all of the financial transactions and census activity of the Provider and affiliated entities including, but not limited to, the books, invoices, bank statements, canceled checks, payroll records, governmental filings, and any other records necessary to document the Provider's reported costs. Providers must be able to document expenses relating to affiliated entities for which it has identified costs related to the care of Massachusetts publicly-aided residents whether or not they are Related Parties.

(c) Fixed Asset Ledger. Providers must maintain a fixed asset ledger which clearly identifies each asset for which expenses are reported, including location, date of purchase, cost, salvage value, accumulated depreciation, and the disposition of sold, lost or fully depreciated assets.

(d) Job Descriptions and Time Records. Providers and management companies must maintain written job descriptions including qualifications, duties, responsibilities, and time records such as time cards for all positions which the Provider identifies as related to the care of Massachusetts publicly-aided residents. Facilities organized as sole proprietors or partnerships in which the sole proprietor or partner functions as administrator with no reported administrator salary or benefits must maintain documentation to support the provision of administrator services by the sole proprietor or partner.

(e) Other Cost Reporting Requirements.

1. Administrative Costs. The following expenses must be reported as administrative:

a. All compensation, including payroll taxes and benefits, for the positions of administrator, assistant administrator, administrator-in-training, business manager, secretarial and clerical staff, bookkeeping staff, and all staff or consultants whose duties are primarily administrative rather than directly related to the provision of on-site care to residents or to the on-site physical upkeep of the Nursing Facility;

b. Expenses related to tasks performed by persons at a management level above that of an on-site Provider department head, which are associated with monitoring, supervising, and/or directing services provided to residents in a Nursing Facility as well as legal, accounting, financial and managerial services or advice including computer services and payroll processing; and

c. Expenses related to policy-making, planning and decision-making activities necessary for the general and Long-Term management of the affairs of a Nursing Facility, including but not limited to the following: the financial management of the Provider, including the cost of financial accounting and management advisory consultants, the establishment of personnel policies, the planning of resident admission policies and the planning of the expansion and financing of the Provider.

d. providers must report the cost of administrative personnel to the appropriate account. The cost of administrative personnel includes all expenses, fees, payroll taxes, fringe benefits, salaries or other compensation.

e. Providers may allocate administrative costs among two or more accounts. The Provider must maintain specific and detailed time records to support the allocation.

2. Draw Accounts. Providers may not report or claim proprietorship or partnership drawings as salary expense.

3. Expenses which Generate Income. Providers must identify the expense accounts which generate income.

4. Fixed Costs.

a. Additions. If the square footage of the Building is enlarged, Providers must report all additions and renovations as Building Additions.

b. Allocation. Providers must allocate all fixed costs, except Equipment, on the basis of square footage. A Provider may elect to specifically identify Equipment related to the Nursing Facility. The Provider must document each piece of Equipment in the fixed asset ledger. If a Provider elects not to identify Equipment, it must allocate Equipment on the basis of square footage.

c. Replacement of Beds. If a Provider undertakes construction to replace beds, it must write off the fixed assets which are no longer used to provide care to Publicly-Aided Residents and may not identify associated expenses as related to the care of Massachusetts publicly-aided residents.

d. Fully Depreciated Assets. Providers must separately identify fully depreciated assets. Providers must report the costs of fully depreciated assets and related accumulated depreciation on all Cost Reports unless they have removed such costs and accumulated depreciation from the Provider's books and records. Providers must attach a schedule of the cost of the retired Equipment , accumulated depreciation, and the accounting entries on the books and records of the Provider to the Cost Report when Equipment is retired.

e. Providers must report all expenditures for major repair projects whose useful life is greater than one year, including, but not limited to, wallpapering and painting as Improvements. Providers may not report such expenditures as prepaid expenses.

5. Laundry Expense. Providers must separately identify the expense associated with laundry services for which non-Publicly-Aided Residents are billed. Providers must identify such expense as non-related to Medicaid patient care.

6. Mortgage Acquisition Costs. Providers must classify Mortgage Acquisition Costs as Other Assets. Providers may not add Mortgage Acquisition Costs to fixed asset accounts.

7. Nursing Costs. The costs must be associated with direct resident care personnel and be required to meet federal and state laws.

8. Related Parties. Providers must disclose salary expense paid to a Related Party and must identify all goods and services purchased from a Related Party. If a Provider purchases goods and services from a Related Party, it must disclose the Related Party's cost of the goods and services.

(f) Special Cost Reporting Requirements.

1. Facilities in which other programs are operated. If a Provider operates an adult day health program, an assisted living program, or provides outpatient services, the Provider may not identify expenses of such programs as related to the care of Massachusetts publicly-aided Residents.

a. If the Provider converts a portion of the Provider to another program, the Provider must identify the existing Equipment no longer used in Nursing Provider operations and remove such Equipment from the Nursing Provider records.

b. The Provider must identify the total square footage of the existing Building, the square footage as sociated with the program, and the Equipment associated with the program.

c. The Provider must allocate all shared costs, including shared capital costs, using a well-documented and generally accepted allocation method. The Provider must directly assign to the program any additional capital expenditures associated with the program.

2. Hospital-Based Nursing Facilities. A Hospital-Based Nursing Provider must file Cost Reports on a fiscal year basis consistent with the fiscal year used in the DHCFP-403 Hospital Cost Report. The Provider must:

a. identify the existing Building and Improvement costs associated with the Nursing Provider. The Provider must allocate such costs on a square footage basis.

b. report major moveable Equipment and fixed Equipment in a manner consistent with the Hospital Cost Report. In addition, the Provider must classify fixed Equipment as either Building Improvements or Equipment in accordance with the definitions contained in 114.2 CMR 6.02. The Provider may elect to report major moveable and fixed Equipment by one of two methods:

1. A Provider may elect to specifically identify the major moveable and fixed Equipment directly related to the care of Publicly-Aided Residents in the Nursing Provider. The Provider must maintain complete documentation in a fixed asset ledger, which clearly identifies each piece of Equipment and its cost, date of purchase, and accumulated depreciation. The Provider must submit this documentation to the Division with its first budgeted Nursing Provider Cost Report.

2. If the Provider elects not to identify specifically each item of major moveable and fixed Equipment , the Division will allocate fixed Equipment on a square footage basis.

c. The Provider must report additional capital expenditures directly related to the establishment of the Nursing Provider within the hospital as Additions. The Division will allocate capital expenditures which relate to the total plant on a square footage basis.

The Provider must use direct costing whenever possible to obtain operating expenses associated with the Nursing Provider. The Provider must allocate all costs shared by the hospital and the Nursing Provider using the statistics specified in the Hospital Cost Report instructions. The Provider must disclose all analysis, allocations and statistics utilized in preparing the Nursing Provider Cost Report.

(2) General Cost Principles. In order to report a cost as related to Medicaid patient care, a cost must satisfy the following criteria:

(a) The cost must be ordinary, necessary and directly related to the care of Publicly-Aided Residents;

(b) The cost must be for goods or services actually provided in the nursing facility; and

(c) The cost must be reasonable; and

(d) The cost must actually be paid by the Provider. Costs which are not considered related to the care of Massachusetts publicly-aided Residents include, but are not limited to: costs which are discharged in bankruptcy; costs which are forgiven; costs which are converted to a promissory note; and accruals of self-insured costs which are based on actuarial estimates;

(e) A provider may not report the following costs as related to the care of Massachusetts publicly-aided Residents:

1. Bad debts, refunds, charity and courtesy allowances and contractual adjustments to the Commonwealth and other third parties;

2 Federal and state income taxes, except the non-income related portion of the Massachusetts Corporate Excise Tax;

3. Expenses that are not directly related to the provision of resident care including, but not limited to, expenses related to other business activities and fund raising, gift shop expenses, research expenses, rental expense for space not required by the Department and expenditure of funds received under federal grants for compensation paid for training personnel and expenses related to grants of contracts for special projects;

4. Compensation and fringe benefits of residents on a Provider's payroll;

5. Penalties and interest, incurred because of late payment of loans or other indebtedness, late filing of federal and state tax returns, or from late payment of municipal taxes;

6. Any increase in compensation or fringe benefits granted as an unfair labor practice after a final adjudication by the court of last resort;

7. Expenses for Purchased Service Nursing services purchased from temporary nursing agencies that are not registered with the Department under regulation 105 CMR 157.000;

8. Any expense or amortization of a capitalized cost which relates to costs or expenses incurred prior to the opening of the facility;

9. All legal expenses; and those accounting expenses and filing fees associated with any appeal process.

(5) Filing Deadlines.